Washington County
MARYLAND

2024-2025
EMPLOYEE BENEFITS GUIDE

Washington County, MD
BOARD OF COUNTY COMMISSIONERS

Welcome to the 2024-2025 Benefits Open Enrollment

The Washington County Commissioners annual insurance open enrollment period is about to begin.

We recognize the importance of benefits within the overall compensation package provided to all of our eligible employees. This year when we reviewed our employee benefits options, we focused not only on providing quality medical plans but also on controlling the cost and financial risk for our employees. We offer multiple options to meet the individual needs of our employees and their dependents.

Open enrollment runs
May 6th– May 17th

Enroll online at
edmw.fa.us2.oraclecloud.com/fscmUI

NOT SURE HOW TO GET STARTED?
DON'T WORRY!

Prior to open enrollment, you will receive step-by-step enrollment instructions.

Until then, now is the perfect time to prepare by doing the following:

- ✔ Check that your personal information is accurate at edmw.fa.us2.oraclecloud.com/fscmUI
- ✔ Review the benefits in which you are currently enrolled
- ✔ Take a look at the changes for 2024-2025
- ✔ Check out the plans being offered for the coming year

In this booklet, you'll find easy-to-understand instructions to help you make your benefit decisions.

As always, we value you as a member of the Washington County Commissioners family and look forward to a healthy and safe 2024.

REMEMBER:

Options selected during the annual open enrollment period will remain in place for the full plan year. Changes can only be made during the annual open enrollment period or within 31 days of certain qualifying life events.

CONTACT INFORMATION

If you have any questions regarding your benefits, please contact one of the carriers listed below or your Human Resources representative.

Medical Insurance
Aetna
aetna.com
(800) 547-5569

Prescription Drug
CVS Caremark
caremark.com
(855) 297-2177

Dental Insurance
Delta Dental
deltadentalins.com
(800) 932-0783

Vision Insurance
EyeMed
www.eyemed.com
(866) 723-0513

Basic Life and AD&D
The Hartford
www.thehartford.com
Contact your Benefits Team

Long-Term Disability
The Hartford
www.thehartford.com
Contact your Benefits Team

Flexible Spending Accounts (FSA)
CBIZ
myplans.cbiz.com
(800) 815-3023
Email: cbizflex@cbiz.com

Employee Assistance Program (EAP)
BHS (Business Health Services)
(800) 327-2251
BHSonline.com
Username: Washco

Your Benefits Team
Jason T. Miller
jtmiller@washco-md.net
Direct: (240) 313-2359
Fax: (240) 203-6355

TABLE OF CONTENTS

Throughout this booklet you will find video and link icons that will take you to resources that provide additional information on the benefits available to you.

MEDICAL INSURANCE

HOW TO GET STARTED

1

SELECT YOUR MEDICAL PLAN

- ☐ **IN-NETWORK (LOW OPTION) (Aetna Select)**
- ☐ **OPEN NETWORK (HIGH OPTION) (Open Choice)**

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

? Will I receive a new Medical ID card?

You will receive an ID card in the mail if you are making changes to your medical coverage.

? Does the deductible run on a calendar year or policy year basis?

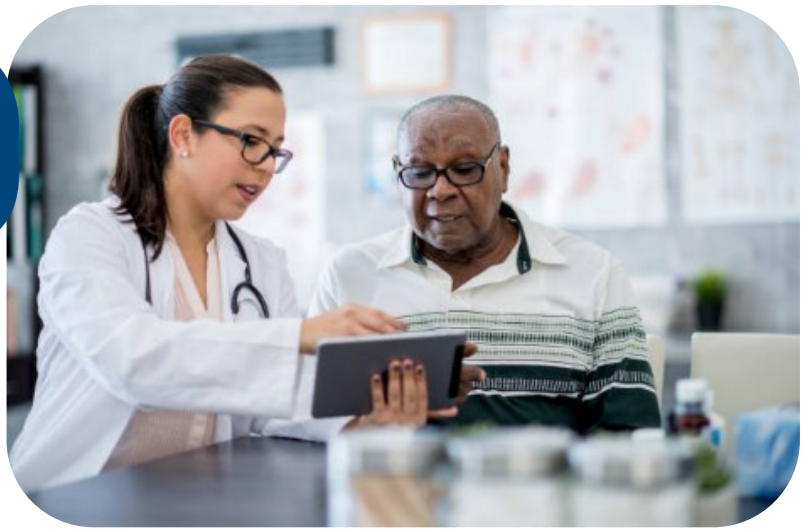
A policy-year basis: July 1, 2024—June 30, 2025

? How long can I cover my dependent children?

Dependent children are eligible until the end of the month in which they turn age 26.

? I just got hired. When will my benefits become effective?

Your medical insurance benefit will begin on the 1st day of the month following date of hire or date of hire if hired on the 1st of the month.



YOUR HEALTH PLAN OPTIONS

As a full-time employee of Washington County Commissioners, you have the choice between two medical plan options:

- In-Network (Low Option)
- Open Network (High Option)

For each, your deductible will run from July 1, 2024—June 30, 2025.

The High Option plan gives you the option of using out-of-network providers, you can save money by using in-network providers because Aetna has negotiated significant discounts with them. If you choose to go out-of-network, you'll be responsible for the difference between the actual charge and Aetna UCR (Usual, Customary and Reasonable) charge, plus your out-of-network deductible and coinsurance.

These plans cover a broad range of healthcare services and supplies. Please refer to the following pages for specific details on the medical plans available to you and your family.

In-Network (Low Option) HIGHLIGHTS:

- No deductible when using in-network providers
- Does not require referrals when seeking care from a specialist
- Lower premium contributions
- Does not provide out-of-network coverage

Open Network (High Option) HIGHLIGHTS:

- No deductible when using in-network providers
- Does not require referrals when seeking care from a specialist
- Higher premium contributions with out-of-network coverage added
- Contains in-network and out-of-network coverage. A deductible applies for out-of-network coverage

▶ Medical Plans Explained

CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the care provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting aetna.com

PRIMARY CARE

- Routine, primary/ preventive care
- Non-urgent treatment
- Chronic Disease Management

TELEHEALTH

- Cold/flu
- Diarrhea
- Fever
- Rash
- Sinus Problems

CONVENIENCE CARE

- Common infections (Ear infections, pink eye, strep throat & Bronchitis)
- Flu shots
- Pregnancy tests
- Vaccines
- Rashes
- Screenings

URGENT CARE

- Sprains
- Small cuts
- Strains
- Sore throats
- Minor infections
- Mild Asthma Attacks
- Back Pain or strains

EMERGENCY ROOM

- Heavy bleeding
- Large open wounds
- Chest pain
- Spinal injuries
- Difficulty breathing
- Major burns
- Severe head injuries

If you believe you are experiencing a medical emergency, go to the nearest emergency room or call 911, even if your symptoms are not described here.

CALL 9-1-1

PRIMARY CARE

- **In-Network (Low Option) $30**
- **Open Network (High Option) $35**

For routine, primary/preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELEDOC

- **In-Network (Low Option) $20**
- **Open Network (High Option) $25**

Teladoc or a "virtual visit", lets you see and talk to a doctor from your mobile device or computer without an appointment, anytime and anywhere! Teladoc bring you care from the comfort and convenience of your home or wherever you are.

URGENT CARE

- **In-Network (Low Option) $35**
- **Open Network (High Option) $35**

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

- **In-Network (Low Option) $200**
- **Open Network (High Option) $200**

An emergency medical condition is any condition (including severe pain) which you believe that, without immediate medical care, may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in- network facility once your condition has been stabilized.

Primary Care vs. Urgent Care vs. ER

MEDICAL INSURANCE PLAN OPTIONS & COSTS

Aetna	In-Network (Low Option)	Open Network (High Option)
	Employee Cost Per Paycheck	**Employee Cost Per Paycheck**
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$27.54 $53.98 $50.12 $77.66	$48.96 $95.96 $89.11 $138.07
	In-Network	**In-Network**
Deductible Individual / Family	$0 / $0	$0 / $0
Coinsurance (Member Pays)	0%	0%
Out-of-Pocket Maximum Individual / Family	$2,000 / $6,000	$2,000 / $6,000
Office Visits Preventative Care Primary Care Physician / Specialist Diagnostic Lab / X-Ray Urgent Care	Covered at 100% $30 / $35 copay Deductible then 0% $35 copay	Covered at 100% $35 / $40 copay Deductible then 0% $35 copay
Hospital Visits Inpatient Care (Facility / Physician) Outpatient Surgery Emergency Room	$100 copay $35 copay $200 copay; waived if admitted	$100 copay $40 copay $200 copay; waived if admitted
Prescription Drug Deductible Retail Tier 1 / 2 / 3 / 4 Copay Mail Order (90-day supply)	N/A $15 / $35 / $50/30%* $30 / $70 / $100	N/A $15 / $35 / $50/30%* $30 / $70 / $100
	Out-of-Network	**Out-of-Network**
Deductible Individual / Family	N/A	$250 / $750
Out-of-Pocket Maximum Individual / Family	N/A	$3,000 / $9,000

Premiums can be withheld from your paycheck on a pre-tax basis for Medical insurance. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change. You must notify Human Resources within 30 days of the event.

Both plans are detailed in Aetna's 2024 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

PrudentRX is a program that works with manufacturers to get copay card assistance for **specialty medications. When you enroll in PrudentRX,Program you will pay $0 for medication on the Specialty Drug List.*

TELEDOC

TELADOC

If you enroll in either health plan, you can connect with a licensed physician via phone or video anytime, anywhere through Teladoc.

Teladoc's U.S. board certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults.

Conditions commonly treated through a virtual visit:

- Bladder infection/ urinary tract infection
- Bronchitis
- Cold/flu
- Diarrhea
- Fever
- Migraine/ headaches
- Pink eye
- Rash
- Sinus problems
- Sore Throat

Registering with Teladoc is quick and easy online. Visit the Teladoc website at Teladoc.com, click "Set up account" and provide the required information.

You may also call Teladoc for assistance over the phone at (800)Teladoc (835-2362).

Once your account is set up, you can call and request a consult any time you need care.

7 REASONS TO REGISTER WITH TELADOC

1. Teladoc provides confidential, convenient, and affordable healthcare 24/7/365.
2. You can speak with a licensed doctor about non-emergency health issues anywhere, whether you're at home, at work, or on vacation.
3. The average wait time to speak with a doctor is 10 minutes.
4. Teladoc doctors can diagnose and treat cold and flu symptoms, upper respiratory infections, ear infections, skin problems, allergy symptoms and more.
5. Teladoc doctors can also send a prescription straight to your pharmacy of choice when medically necessary.
6. You dependents are eligible to receive care from Teladoc, including adult children up to age 26.
7. You can connect with Teladoc by phone, web, or mobile app.

(800) Teladoc (835-2362) teladoc.com

FLEXIBLE SPENDING ACCOUNTS (FSA)

2 SELECT YOUR FSA ACCOUNTS

- ☐ **Health Care Flexible Spending Account**
- ☐ **Dependent Care Expense Account**

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

This account enables you to pay medical, dental, vision, and prescription drug expenses that may or may not be covered under your insurance program (or your spouse's) with pre-tax dollars. You can also pay for dependent health care, even if you choose single (vs. family) coverage. The total amount of your annual election is available to you up front, reducing the chance of having a large out-of-pocket expense early in the plan year. Be aware—maximum carryover at the end of the plan year is $500.

Eligible Expenses Examples	
• Coinsurance and copayments	• Laboratory fees
• Contraceptives	• Licensed practical nurses
• Crutches	• Orthodontia
• Dental expenses	• Orthopedic shoes
• Dentures	• Oxygen
• Diagnostic expenses	• Prescription drugs
• Eyeglasses, including exam fee	• Psychiatric care
• Handicapped care and support	• Psychologist expenses
• Nutrition counseling	• Routine physical
• Hearing devices and batteries	• Seeing-eye dog expenses
• Hospital bills	• Prescribed vitamin supplements (medically necessary)
• Deductible Amounts	

[What is a Flexible Spending Account?]

[Full list of Eligible Examples]

2024 Maximum Contributions

Health Care Flexible Spending Account	$3,200 max
Dependent Care Expense Account	$5,000 max

How the Health Care Flexible Spending Account Works

When you have out-of-pocket expenses (such as copayments and deductibles), you can either use your FSA debit card to pay for these expenses at qualified providers or submit an FSA claim form with your receipt to CBIZ. Reimbursement is issued to you through direct deposit into your bank account, or if you prefer, a check can be issued to you.

DEPENDENT CARE EXPENSE ACCOUNT

This account gives you the opportunity to redirect a portion of your annual pay on a pre-tax basis to pay for dependent care expenses. An eligible dependent is any member of your household for whom you can claim expenses on your Federal Income Tax Form 2441, "Credit for Child and Dependent Care Expenses." Children must be under age 13. Care centers which qualify include dependent care centers, preschool educational institutions, and qualified individuals (as long as the caregiver is not a family member and reports income for tax purposes). Before deciding to use the Dependent Care Expense Account, it would be wise to compare its tax benefit to that of claiming a child care tax credit when filing your tax return. You may want to check with your tax advisor to determine which method is best for you and your family. Any unused portion of your account balance at the end of the plan year is forfeited.

Contact Information

Request a full statement of your accounts at any time by calling (800) 815-3023 or log on to myplans.cbiz.com to review your FSA balance. The address to mail claims to is CBIZ Payroll (Attn: Flex), 2797 Frontage Road, Suite 2000, VA 24017

At myplans.cbiz.com you can:

- View account information and activity
- File claims
- Manage your profile
- View notifications
- Access forms

DENTAL INSURANCE

3 REVIEW YOUR DENTAL PLAN

DELTA DENTAL

FIND A DENTIST

To find a Delta Dental provider in your area, visit the website at deltadentalins.com.

DELTA DENTAL IS THE DENTAL CARRIER FOR 2024-2025.

The dental plan is a PPO that offers coverage in and out-of-network. It is to your advantage to utilize a network dentist in order to achieve the greatest cost savings. If you choose to go out-of-network, you will be responsible for any cost exceeding Delta Dental's negotiated fees, plus any deductible and coinsurance associated with your procedure.

Dependent children are eligible until the end of the month in which they turn age 26.

There is no coverage for braces under either plan.

In-Network Providers:
Provider is reimbursed based on contracted fees and cannot balance bill you.

Out-of-Network Providers:
Provider is reimbursed based on Reasonable and Customary standards and balance billing is possible.

DENTAL INSURANCE PLAN OPTIONS & COSTS

Delta Dental	Low Option Plan		High Option Plan	
	Employee Cost Per Paycheck		Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$6.19 $11.83 $10.99 $17.02		$7.75 $15.48 $14.39 $22.28	
	PPO Dentist	Non-PPO Dentist	PPO Dentist	Non-PPO Dentist
Deductible Individual / Family	$50 / $150	$50 / $150	$50 / $150	$100 / $300
Annual Maximum	$1,000	$1,000	$1,000	$1,000
	Carrier Pays			
Diagnostic/Preventive Services (i.e. cleaning)	Carrier pays 80%	Carrier pays 80%	Carrier pays 100% (no deductible)	Carrier pays 80%
Basic Services (i.e. fillings, extractions)	80%	80%	90%	70%
Major Services (i.e. crowns, dentures)	50%	50%	80%	60%

What is Dental Insurance?

VISION INSURANCE

4 REVIEW YOUR VISION PLAN

FIND A PROVIDER

To find a EyeMed Vision provider in your area, visit the website at www.eyemed.com.

EYEMEDVISION IS THE VISION CARRIER FOR 2024-2025.

The vision plan offers coverage both in-network and out-of-network. It is to your advantage to utilize a network provider in order to achieve the greatest cost savings. If you go out-of-network, your benefit is based on a reimbursement schedule.

Also, if you are considering Lasik surgery or other non-covered benefits, there are discounts available with some providers.

VISION INSURANCE PLAN OPTIONS & COSTS

EyeMed	Low Option (24 Months)		High Option (12 Months)	
	Employee Cost Per Paycheck		Employee Cost Per Paycheck	
Employee Employee + Spouse Employee + Child(ren) Employee + Family	$2.57 $4.36 $4.17 $5.64		$3.29 $5.46 $5.22 $8.18	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examination Copay	Plus Providers: $0 copay All Other In: $0 Copay	Reimbursement Plus Providers: Up to $40 All Other In: Up to $40	Plus Providers: $0 copay All Other In: $0 Copay	Reimbursement Plus Providers: Up to $40 All Other In: Up to $40
Frequency of Service Exam Lenses Frames	Every 24 months Every 24 months Every 24 months		Every 12 months Every 12 months Every 12 months	
Lenses Single Bifocal Trifocal Lenticular	100% covered 100% covered 100% covered 100% covered	Reimbursement Up to $40 Up to $60 Up to $80 Up to $80	100% covered 100% covered 100% covered 100% covered	Reimbursement Up to $40 Up to $60 Up to $80 Up to $80
Frames	Plus Providers: $0 Copay, 20% off balance over $180 allowance All other In: $0 Copay, 20% off balance over $130 allowance	Reimbursement PLUS Providers: Up to $91 All other in: Up to $91	Plus Providers: $0 Copay, 20% off balance over $180 allowance All other In: $0 Copay, 20% off balance over $130 allowance	Reimbursement PLUS Providers: Up to $91 All other in: Up to $91
Elective Contacts Lenses	Disposable- $0 Copay; 100% of balance over $125 allowance	Reimbursement Up to $125	Disposable- $0 Copay; 100% of balance over $125 allowance	Reimbursement Up to $125
Medically Necessary Contacts in lieu of lenses/frames*	100% Covered	Reimbursement Up to $300	100% Covered	Reimbursement Up to $300

*Allowances include the contact lens and fitting

What is Vision Insurance?

EMPLOYEE ASSISTANCE PROGRAM

5 **REVIEW YOUR EAP BENEFITS**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The BHS EAP is a free, confidential service provided to all Full-Time employees and their household dependents.

Through BHS, employees and household members receive assistance for a variety of mental health and other family issues such as financial, identity recovery assistance, daily living services and child and elder care. There is also a legal plan option that covers many routine legal issues.

This program offers a wide variety of counseling and assessments, referrals, prevention services, education re-sources, and consultation services which are all designed to assist you and your family.

bhsonline.com

(800) 327-2251

Username: Washco

Common Reasons to Call Your EAP			
Relationships	**Transitions**	**Risks**	**Challenges**
Boss/Coworkers	Birth/Death	Burnout/Anger	Daily Responsibilities
Customers	Health/Illness	Depression/Anxiety	Financial/Legal
Friends	Marriage/Divorce	Suicidal/Thoughts	Parenting
Spouse/Kids	Promotion/Retirement	Substance Abuse	Stress/Conflict

LIFE AND DISABILITY

REVIEW YOUR LIFE AND DISABILITY POLICIES

- ☐ **Basic Life and AD&D**
- ☐ **Long-Term Disability**
- ☐ **Short-Term Disability**

BASIC LIFE AND AD&D FOR YOU AND YOUR DEPENDENTS—FROM THE HARTFORD

- Lie Insurance Coverage is 1x your annual earnings to a maximum of $100,000
- AD&D coverage is 2x your annual earnings to a maximum of $60,000.
- Dependent Life: Spouse: $2,000. Child: $1,000

This coverage is provided at no cost to you.

LONG-TERM DISABILITY—FROM THE HARTFORD

Base Plan- Payable at 40% of your salary, which is provided at no cost.

Buy-Up Plan- at the time of hire you have/would have had the option to Buy-Up for an extra 20%. This is paid for through biweekly payroll deductions. The biweekly cost is dependent upon your age and salary. This amount will increase with your age and salary.

Benefit Waiting Period- After 180 days disabled

Maximum Benefit- $5,000 per month

Minimum Benefit- $100 per month

SHORT-TERM DISABILITY COVERAGE

- Runs concurrently with FMLA Leave.
- For all injuries or illnesses that are not work related.
- There is a 15 calendar day waiting period from your first day off work due to the injury or illness.
- You must use all sick leave before using STD benefits
- Coverage is 70% of your wages with a maximum of $1600 biweekly for up to 13 weeks. Benefits, taxes, and other deductions will be taken out of the at 70% that you are eligible to receive.
- This coverage is offered at no cost to you.

What is Life and AD&D Insurance?

What is Disability Insurance?

VIDEO LIBRARY

MEDICAL PLANS

- Medical Plans Explained
- Primary Care vs. Urgent Care vs. ER
- PPO Overview

OPEN ENROLLMENT RUNS
APRIL 24TH- MAY 12TH

INSURANCE 101

- Benefits Key terms Explained
- How to Read an EOB
- What is a Qualifying Event?

TAX ADVANTAGE SAVINGS ACCOUNTS

- What is a Flexible Spending Account?

ANCILLARY BENEFITS

- What is Dental Insurance?
- What is Vision Insurance?

INSURANCE TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

MEDICAL TERMS

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

IMPORTANT NOTICES

MEDICARE PART D CREDITABLE COVERAGE

Important Notice from Washington County Commissioners About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Washington County Commissioners and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Washington County Commissioners has determined that the prescription drug coverage offered by the Aetna health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Washington County Commissioners coverage **may** be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Washington County Commissioners medical plan, **be aware that you and your dependents may not be able to get this coverage back**.

IMPORTANT NOTICES

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Washington County Commissioners and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Washington County Commissioners changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2024
Name of Entity/Sender:	Washington County Commissioners
Contact--Position/Office:	Jason T. Miller - Benefits Coordinator
Address:	100 West Washington Street, Hagerstown, MD 21740
Phone Number:	240-313-2359
Fax:	240-203-6355

IMPORTANT NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

IMPORTANT NOTICES

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

IMPORTANT NOTICES

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

IMPORTANT NOTICES

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

IMPORTANT NOTICES

FAMILY AND MEDICAL LEAVE ACT (FMLA)

ELIGIBLITY

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50employees within 75 miles of the employee's worksite.

WHAT CAN FMLA BE TAKEN FOR?

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.
- An eligible employee who is a covered service member's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the service member with a serious injury or illness.
- An employee does not need to use leave in one block. When itis medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.
- Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

This notice is intended as a brief outline; please HR for more information

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator 240-313-2359.

MARKETPLACE COVERAGE OPTIONS

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1] [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

MARKETPLACE COVERAGE OPTIONS

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

MARKETPLACE COVERAGE OPTIONS

PART B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name: Board of Washington County Commissioners	**4. Employer Identification Number (EIN):** 52-6001037
5. Employer Address: 100 West Washington Street	**6. Employer Phone Number:** 240-313-2350
7. City: Hagerstown	**8. State:** Maryland **9. ZIP Code:** 21740
10. Who can we contact about employee health coverage at this job? Jason T. Miller	
11. Phone number (if different from above): 240-313-2359	**12: Email address:** jtmiller@washco-md.net

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☑ All employees. Eligible employees are: Full-time employees working a minimum 30 hours per week on a regular basis. Employees will be effective the 1st day of the month, following date of hire or date of hire if hired on the 1st of the month.

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are: Spouse and children to age 26, regardless of student status.

  ☐ We do not offer coverage.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Above is the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Washington County, MD

BOARD OF COUNTY COMMISSIONERS

The purpose of this booklet is to describe the highlights of your benefit program. Your specific rights to benefits under the Plans are governed solely, and in every respect, by the official plan documents and insurance contracts, and not by this booklet. If there is any discrepancy between the description of the plans as described in this material and official plan documents, the language of the documents shall govern.